

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN8308	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/22/2020
NAME OF PROVIDER OR SUPPLIER NHC PLACE SUMNER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 THORNE BOULEVARD GALLATIN, TN 37066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies This Rule is not met as evidenced by: During the complaint investigation of TN00050286 on 01/22/2020, no deficiencies were cited under 1200-08-6, Standards for Nursing Homes.	N 002		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE